SCOPE:

County Mental Health/Mental Retardation Administrators

PURPOSE:

The purpose of this bulletin is to transmit the Department’s approved Infants, Toddlers and Families Medicaid Waiver renewal application, effective July 1, 2001.

BACKGROUND:

The Department received initial Centers for Medicare and Medicaid Services (CMS) approval for the Medicaid Waiver for Infants, Toddlers and Families on October 16, 1997. Implementation was postponed until July 1, 1998 in accordance with the CMS’ August 13, 1998 approval of a waiver amendment. This amendment resulted in a change in the effective date of this waiver to the three-year period beginning July 1, 1998.

Following the initial three years of service operation, Home and Community Based Waiver services provided under section 1915C of the Social Security Act are approved by the CMS for five-year renewal periods. Medicaid Waiver renewals are based on satisfactory provision of waiver services, meeting state assurances, and a written application that describes how services will be provided during the renewal period.
INFORMATION:

CMS approved the Pennsylvania Department of Public Welfare’s application for a five-year renewal of its Medicaid Waiver for Infants, Toddlers and Families. The renewal period, based on CMS’ attached letter to Secretary Feather O. Houston, is from July 1, 2001 to June 30, 2006. The attached waiver application establishes the framework for the provision of waiver services during the renewal period.

The only changes to the Medicaid Waiver for Infants, Toddlers and Families are minor post-eligibility changes. These changes, which are reflected on pages 22-24 of this bulletin, are consistent with the manner in which financial eligibility is determined. No change in current practices is required.

Specific County responsibilities related to the provision of Medicaid Waiver Services for Infants, Toddlers and Families are stipulated in the Supplemental Grant Agreement (SGA) between County MH/MR Programs and the Department. The County’s current SGA (MR Bulletin 00-98-05, issued July 1, 1998) will continue to be in effect until superceded by a new grant agreement.

Any future amendments to this waiver application will be distributed under the Mental Retardation Bulletin format, once the amendment receives CMS approval. County MH/MR Programs will be responsible for instituting changes necessitated by such amendments based on instructions provided by the Department.

All County MH/MR Programs participating in the waiver are expected to retain a copy of the approved waiver application, and any future amendments for the duration of the five-year renewal period.
Re: Renewal of Pennsylvania's Home and Community-Based Services Waiver for Infants, Toddlers and Families (CMS Control # 0324.90)

Dear Ms. Houstoun:

I am pleased to inform you that your request dated June 26, 2001, as supplemented by the additional information dated September 14, 2001, to renew your Home and Community-Based Services Waiver for Infants, Toddlers and Families has been approved. The waiver, authorized under the provisions of § 1915(c) of the Social Security Act, will enable the Commonwealth to provide home and community-based services, specifically habilitation, to individuals from birth to their third birthday who are experiencing developmental delays. Individuals served in the waiver would otherwise require institutional care in an intermediate care facility for the mentally retarded or persons with related conditions. This waiver now will carry CMS control number 0324.90. Please refer to this number in all future correspondence regarding this waiver renewal.

Based on the assurances and information you provided, I approve the waiver renewal request cited above for a 5-year period, effective July 1, 2001, the date you requested. This approval is subject to your agreement to provide home and community-based services, on an annual basis, to no more individuals than those indicated as the value of "C" in your approved per capita expenditure estimates (shown below).

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>“C” Value</th>
<th>“D” Value</th>
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<tbody>
<tr>
<td>Year 1</td>
<td>July 1, 2001 - June 30, 2002</td>
<td>3,730</td>
</tr>
<tr>
<td>Year 2</td>
<td>July 1, 2002 - June 30, 2003</td>
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<tr>
<td>Year 3</td>
<td>July 1, 2003 - June 30, 2004</td>
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<td>Year 4</td>
<td>July 1, 2004 - June 30, 2005</td>
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<tr>
<td>Year 5</td>
<td>July 1, 2005 - June 30, 2006</td>
<td>3,730</td>
</tr>
</tbody>
</table>

Please contact Bill Davis of the Philadelphia Regional Office at (215) 861-4204 if you have any questions.

Sincerely,

Patricia L. Harris
Acting Regional Administrator
1. The State of Pennsylvania requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.
   
   a. ____ Yes  
   b. _X_ No

   If yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):
   
   a. ____ 3 years (initial waiver)
   b. _X_ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels(s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a. _____ Nursing facility (NF)
   b. _X_ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

STATE___________________________  -1-  DATE: _______________________
c. _____ Hospital

d. _____ NF (served in hospital)

e. _____ ICF/NM (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

a. _____ aged (age 65 and older)

b. _____ disabled

c. _____ aged and disabled

d. _____ mentally retarded

e. _____ developmentally disabled

f. **X** mentally retarded and developmentally disabled

g. _____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a. **X** Waiver services are limited to the following age groups (specify):

   birth to age 3

b. _____ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):

c. _____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d. **X** Other criteria. (Specify):

   Infant or toddler needs early intervention services.
5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-I in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.
   a. X Yes          b. ___ No

7. A waiver of § 1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.
   a. X Yes          b. ___ No          c. ___ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.
   a. X Yes          b. ___ No

9. A waiver of the "statewidness" requirements set forth in section 1902(a)(1) of the Act is requested.
   a. ___ Yes         b. X No

   If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.I of this request, be included under this waiver:
   a. ___ Case management
   b. ___ Homemaker/Chore
   c. ___ Home health aide services
   d. ___ Personal care services

STATE: _______________________  -3-   DATE: ____________________

VERSION 06-95
e. _____ Respite care
f. _____ Adult day health
g. X Habilitation
    _____ Residential habilitation
    _____ Day habilitation
    _____ Revocational services
    _____ Supported employment services
    _____ Educational services
h. _____ Environmental accessibility adaptations
i. _____ Skilled nursing
j. _____ Transportation
k. _____ Specialized medical equipment and supplies
l. _____ Chore services
m. ____ Personal Emergency Response Systems
n. ____ Companion services
o. ____ Private duty nursing
p. ____ Family training
q. ____ Attendant care
r. _____ Adult Residential Care
    _____ Adult foster care
    _____ Assisted living

STATE: _________________________  -4-  DATE: _________________________
s. Extended State plan services (Check all that apply):

_____ Physician services  
_____ Home health care services  
_____ Physical therapy services  
_____ Occupational therapy services  
_____ Speech, hearing and language services  
_____ Prescribed drugs  
_____ Other (specify):

 t. Other services (specify):

_____ Visual/mobility therapy, Behavior therapy & Visiting nurse.  
_____ Adaptive appliances and equipment  
_____ Personal Support

u. The following services will be provided to individuals with chronic mental illness:

_____ Day treatment/Partial hospitalization  
_____ Psychosocial rehabilitation  
_____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care, the Individualized Family Services Plan - IFSP, will be developed by qualified individuals for each individual under this waiver. This IFSP will describe the medical and other services and support (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services and support will be furnished pursuant to the written IFSP. The plan will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the IFSP. FFP will not be claimed for waiver services that are not included in the individual written IFSP.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.
15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. _____ When provided as part of respite care that is not a private residence (see definition for State approved settings).

b. _____ Meals furnished as part of a program of adult day habilitation services.

c. _____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means three meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B)

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home- and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.
b. The agency will provide for an evaluation of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services, but for the availability of home- and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.
i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.


a. \( \textbf{X} \) Yes \hspace{1cm} b. \( \text{____} \) No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality. The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. \( \text{____} \) Yes \hspace{1cm} b. \( \textbf{X} \) No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served under the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care needs of the individuals are met.

Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to persons served under the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

19. An effective date of July 1, 2001 is requested.

20. The State contact person for this request is Mel Knowlton who can be reached at (717) 783-5764, or Cathleen Berkey who can be reached at (717) 783-5058.
This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: ________________________

Print Name: Feather 0. Houstoun

Title: Secretary of Public Welfare

Date: JUN 26 2001
APPENDIX A- ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

__________ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

__________ The waiver will be operated by a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy are on file at the Medicaid agency.

__________ The waiver will be operated by the State Office of Mental Retardation (OMR), a separate division within the Single State agency. OMR exercises administrative discretion in the administration and supervision of the waiver and issues, policies, rules and regulations related to the waiver.

STATE: _______________________  -10-  DATE: ________________________
APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2.

f. **X** Habilitation:

   **X** Other definition (Specify):

Habilitation consists of a range of services provided for the child by a qualified professional with the participation of the child's family or caregiver.

Services can be provided directly to the child while the family or caregiver is present and participating, or services can be provided as instruction to the family or caregiver to benefit the child's development in everyday life.

For purposes of this waiver, family means a parent, guardian, surrogate parent, or person acting as parent of the child. A caregiver means a person responsible for providing care for the child in the home and community, such as a relative, day care provider, or another adult at the family's discretion.

Instruction to families and caregivers is limited to service techniques, information and, procedures which the family or caregiver needs to support the child's development.

Participation of the family or caregiver is based on their willingness and ability as determined by the family or caregiver, the child's multi-disciplinary team and the provider of service.

Habilitation funded under this waiver must be provided in a natural environment which means the child's home, the home of a relative or friend, or a community setting that is typical for the child's age peers where children without a disability are likely to attend.

Habilitation consists of the assistance and acquisition, retention or improvement of skills related to activities of daily living, such as feeding and dressing, communication with caregivers; orientation and mobility, and social development needed by the child.

Qualifications of the providers are indicated in Appendix B-2. Habilitation, which is provided by therapists and health care professionals, is rendered in accordance with each professional's scope of practice. Habilitation by an early interventionist consists of assistance and instruction in designing learning environments and activities in the home and community to promote the child's acquisition of skills, cognitive process, and social integration.
Habilitation includes the cost of transportation for the provider's travel to the child's home or community services/ activities; consultation with professionals; and participation in the multidisciplinary team process.

Instruction in the application of an assistive device funded through another funding source is an eligible waiver services to the extent that the other funding source does not provide needed family and caregiver instruction in the home and community.

Habilitation providers cannot be limited in any way which would violate the Department's assurance of freedom of choice. No qualified provider of service can be denied access to providing services on the basis of single source contracting or other practices, which would deny or limit a family's choice of qualified providers. In addition, children participating in the waiver will maintain access to all services covered in the State Plan, including EPSDT, with free choice of providers.

The following services and activities are excluded from Federal and State financial participation under this waiver:

- professional Services provided directly to a child without the participation of a family member or caregiver.
- services rendered in a clinic, provider's office or office area, or outside of a natural environment as defined by this application.
- medical and surgical procedures; the cost of medicine and drugs for these purposes; medical supplies and equipment including wheelchairs, splints and orthopedic devices; and devices necessary to control or treat a medical condition
- personal care services, services provided by a family or caregiver, day care services, respite care services, family aide and preschool services.
- participation of the family or caregiver in service delivery, together with care or services provided by the family or caregiver as a result of the participation.
- assistive technology, including purchase and leasing of computer hardware or software that constitutes assistive technology.
APPENDIX B-2 PROVIDER QUALIFICATION

A. LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, and State Administration Code is referenced by citation. Standards not addressed under uniform State citation are attached.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PROVIDER</th>
<th>LICENSE</th>
<th>CERTIFICATION</th>
<th>OTHER STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Habilitation</td>
<td>Nurse and other Qualified health care professionals</td>
<td>Registered Nurse (RN)</td>
<td>Certification</td>
<td>Certified Registered Nurse (CRNP)</td>
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<tr>
<td></td>
<td></td>
<td>Licensed Practical Nurse (LPN)</td>
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<td>Title 49</td>
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<td>Title 49 Professional and Vocational</td>
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<td></td>
<td>Standards-Chapter 21 State Board of Nursing</td>
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<td>Vocational</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Standards-Chapters 16, 17 and 18 State Board of</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medicine</td>
</tr>
</tbody>
</table>

All services must conform to the County MH/MR Program Fiscal Manual, 55 Pa. Code Ch.4300, and conditions of the County Grant Agreement for waiver services with the Department.
### Pennsylvania

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PROVIDER</th>
<th>LICENSURE</th>
<th>CERTIFICATION/REGISTERED</th>
<th>OTHER STANDARD</th>
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<td>Habilitation</td>
<td>Physical therapist</td>
<td>Licensed physical therapist Title 49 Professional and Vocational Standards-Chapter 40 State Board of Physical Therapy</td>
<td>Registered Physical Therapist Assistant (PTA)</td>
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<td>Title 49 Professional and Vocational Standards-Chapter 40 State Board of Physical Therapy</td>
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<td>Habilitation</td>
<td>Occupational therapist</td>
<td>Licensed Occupational Therapist (OTR/L) Title 49 Professional and Vocational Standards-Chapter 42 State of Occupational Therapy</td>
<td>Certification Occupational Therapist Assistant (COTA/L) Title 49 Professional and Vocational Standards-Chapter 42 State Board of Occupational Therapy</td>
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STATE: _________________________________ -14- DATE: _______________________

Revised 7/1/99
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<th>LICENSE</th>
<th>CERTIFICATION</th>
<th>OTHER STANDARD</th>
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<tbody>
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<td>Habilitation</td>
<td>Nurse</td>
<td>Registered Nurse (RN) Licensed Practical Nurse (LPN) Title 49 Professional and Vocational Standards-Chapter 21 State Board of Nursing</td>
<td>Certification Certified Registered Nurse Practitioner (CRNP) Title 49 Professional and Vocational Standards-chapter 18 State Board of Medicine and Chapter 21 State Board of Nursing</td>
<td>Certified Registered Nurse (CRNP) Title 49 Professional and Vocational Standards-Chapters 16, 17 and 18 State Board of Medicine</td>
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<td>Habilitation</td>
<td>Early Interventionist</td>
<td>Licensed Teacher of the Hearing Impaired Title 49 Professional and Vocational Standards-Chapter 45 State Board of Examiners in Speech/Language and Hearing</td>
<td>Certification Teacher of Special Education Teacher of Early Childhood Teacher of the Visual Impaired, Mentally and/or Physically Handicapped, Hearing Impaired and Speech and Language Impaired PA Department of Education</td>
<td>Early Interventionist-County Certified requiring: -bachelor’s degree or above from accredited college or university and one year volunteer experience working directly with children, families or people with disabilities or in counseling. -an associates degree, or 60 credit hours from an accredited college or university and three years work or volunteer experience working directly with families, children, or people with disabilities, or counseling.</td>
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<td>LICENSURE</td>
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<tr>
<td>Habilitation</td>
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<td>Licensed Psychologist</td>
<td></td>
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<td></td>
<td></td>
<td>Title 49</td>
<td>Professional and Vocational Standards-Chapter 41 State Board of Psychology</td>
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<td></td>
<td>Registered Dietician, or</td>
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<td></td>
<td>Dietician</td>
<td></td>
<td>Certified Nutritionist PA Department of Education</td>
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<td>Social Worker</td>
<td>Licensed Social Worker. (LSW)</td>
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<td>Title 49 Professional and Vocational Standards-Chapter 47 State Board of Social Work Examiner</td>
<td>Title 49 Professional and Vocational Standards-Chapter 47 State Board of Social Work Examiners</td>
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</table>
B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law of regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

STATE: ________________________ -17- DATE: ________________________
APPENDIX B-3

KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

_____ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

X  A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

STATE: _______________________  -18-  DATE: _______________________
Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. (Check all that apply.)

1. X Low-income families with children as described in section 1931 of the Social Security Act.

2. X SSI recipients (SSI) Criteria States and 1634 States).

3. Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. X Optional State supplement recipients

5. Optional categorically needy aged and disabled who have income at (Check one):
   a. 100% of the Federal poverty level (FPL)
   b. % Percent of FPL which is lower than 100%..

6. X The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in an institution, who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).
Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

Check one:

_____ A. Yes     X B. No

a.  X The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community based services in order to remain in the community; or

b.   Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based Services in order to remain in the community are included in this waiver: (check all that apply):

(1)  A special income level equal to:

_____ 300% of the SSI Federal benefit (FBR)

_____ % of FBR, which is lower than 300% (42 CFR 435.236)

$____ which is lower than 300%

(2)  Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)   Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435.324.)

(4)  Medically needy without spenddown in 209(b) States. (42 CFR 43 5.3 3 0)

(5)  Aged and disabled who have income at:

a.   100% of the FPL

b.   % which is lower than 100%.

(6)   Other (Include statutory reference only to reflect additional groups included under the State plan.)

(7)   Medically needy (42 CFR 435.320, 435.322, 435,324 and. 435.330)

(8)   Other

STATE: _________________________ -20- DATE: ____________
Appendix C-2--Post-Eligibility

GENERAL INSTRUCTIONS

ALL Home and Community-Based waiver recipients found eligible under 435.217 are subject to post-eligibility calculations.

Eligibility and post-eligibility are two separate processes with two separate calculations. Eligibility determines whether a person may be served on the waiver. Post-eligibility determines the amount (if any) by which Medicaid reduces its payment for services furnished to a particular individual. By doing so, post-eligibility determines the amount (if any) for which an individual is liable to pay for the cost of waiver services.

An eligibility determination (and periodic redetermination) must be made for each person served on the waiver.

Post-eligibility calculations are made ONLY for persons found eligible under §435.217.

Post-eligibility determinations must be made for all groups of individuals who would be eligible for Medicaid if they were in a medical institution and need home and community-based services in order to remain in the community (§435.217). For individuals whose eligibility is not determined under the spousal rules (§ 1924 of the Social Security Act), the State must use the regular post-eligibility rules at 435.726 and 435.735. However, for persons found eligible for Medicaid using the spousal impoverishment rules, the State has two options concerning the application of post-eligibility rules:

OPTION 1: The State may use the post-eligibility (PE) rules under 42 CFR §435.726 and §435.735 just as it does for other individuals found eligible under §435.217 or;

OPTION 2: it may use the spousal post-eligibility rules under RULES-§4435.7261924.

REGULAR POST-ELIGIBILITY RULES-§4435.726 and 4435.735

• The State must provide an amount for the maintenance needs of the individual. This amount must be based upon a reasonable assessment of the individual's needs in the community.

• If the individual is living with his or her spouse, or if the individual is living in the community and the spouse is living at home, the State must protect an additional amount for the spouse's maintenance. This amount is limited by the highest appropriate income standard for cash assistance, or the medically needy standard. The State may choose which standard to apply.

• If the individual's spouse is not living in the individual's home, no maintenance amount is protected for that spouse's needs.
If other family members are living with the individual, an additional amount is protected for their needs. This amount is limited by the AFDC need standard for a family of the same size or by the appropriate medically needy standard for a family of the same size. The State may choose which standard to apply.

**SPOUSAL POST-ELIGIBILITY-41924**

When a person who is eligible as a member of a 42 CFR 435.217 group has a community spouse, the State may treat the individual as if he or she is institutionalized and apply the post-eligibility rules of § 1924 of the Act (protection against spousal impoverishment) instead of the posteligibility rules under 42 CFR 435.726 and 435.735. The §1924 post-eligibility rules provide for a more generous community spouse and family allowance than the rules under 42 CFR 43 5.726 and 43 5.73 5. Spousal impoverishment post-eligibility rules can only be used if the State is using spousal impoverishment eligibility rules.

The spousal protection rules also provide for protecting a personal needs allowance (PNA) "described in § 1902(q)(1)" for the needs of the institutionalized individual. This is an allowance which is reasonable in amount for clothing and other personal needs of the individual ... while in an institution." For institutionalized individuals this amount could be as low as $30 per month. Unlike institutionalized individuals whose room and board are covered by Medicaid, the personal needs of the home and community-based services recipient must include a reasonable amount for food and shelter as well as for clothing. The $30 PNA is not a sufficient amount for these needs when the individual is living in the community.

Therefore, States which elect to treat home and community-based services waiver participants with community spouses under the § 1924 spousal impoverishment post-eligibility rules must use as the personal needs allowance either the maintenance amount which the State has elected under 42 CFR 435.726 or 42 CFR 435.735, or an amount that the State can demonstrate is a reasonable amount to cover the individual's maintenance needs in the community.

**POST ELIGIBILITY**

**REGULAR POST ELIGIBILITY**

1. **X** SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts from the waiver recipient's income.

   A. **§435.726**--States which do not use more restrictive, eligibility requirements than SSI.

   STATE: _________________________ -22- DATE: ________________

Revised 09/28/01
a. Allowances for the needs of the

1. individual: (Check one)

   A. ___ The following standard included under the State plan (check one):

      (1)_____SSI

      (2)_____Medically needy

      (3) X The special income level for the institutionalized (300% of the Federal SSI Benefit Rate)

      (4)_____The following percent of the Federal poverty level): ____ %

      (5) _____Other (specify):

      __________________________________________

   B. ___ The following dollar amount:

      $_____ *

     * If this amount changes, this item will be revised.

   C. ___ The following formula is used to determine the needs allowance:

      Note: If the amount protected for waiver recipients in item 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under 42 CFR 435.217, enter NA in items 2. and 3. following.

2. spouse only (check one):

   A.____ SSI standard

   B.____ Optional State supplement standard

   C.____ Medically needy income standard

   D.____The following dollar amount:

STATE: __________________________ -23- DATE: _________________

Revised 08/28/01
*If this amount changes, this item will be revised.

E.____ The following percentage of the following standard that is not greater than the standards above: % of standard.

F.____ The amount is determined using the following formula:

G. X Not applicable (N/A)

3. Family (check one):

A.____ AFDC need standard

B.____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family, of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.____ The following dollar amount: $____

*If this amount changes, this item will be revised.

D.____ The following percentage of the following standard that is not greater than the standards above: ____% of standard.

E.____ The amount is determined using the following formula:

F.____ Other

G. X Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435,726.

STATE: _____________________ -24- DATE: ______________

Revised 08/28/01
POST-ELIGIBILITY

REGULAR POST ELIGIBILITY

1.(b) 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts from the waiver recipient's income.

B. 42 CFR 435.735--States using more restrictive requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. The following standard included under the State plan (check one):

(l) SSI

(2) Medically needy

(3) The special income level for the institutionalized

(4) The following percentage of the Federal poverty level: ____%

(5) Other (specify):

B. The following dollar amount:

$___*

* If this amount changes, this item will be revised.

C. The following formula is used to determine the amount:

STATE: _________________________ -25- DATE: _________________
Note: If the amount protected for waiver recipients in 1. is equal to, or greater than the maximum amount of income a waiver recipient may have and be eligible under §43 5.217, enter NA in items 2. and 3. following.

2._____ spouse only (check one):
   
   A. ___ The following standard under 42 CFR 43 5.12 1:
   
   B. ___ The medically needy income standard;
   
   C. ___ The following dollar amount:
   $___*
   
   *If this amount changes, this item will be revised.
   
   D. ___ The following percentage of the following standard that is not greater than the standards above: _____% of
   
   E. ___ The following formula is used to determine the amount:
   
   F. ___ Not applicable (N/A)

3._____ family (check one):
   
   A. ___ AFDC need standard
   
   B. ___ Medically needy income standard
   
   The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.
   
   C. ___ The following dollar amount:
   $___*
*If this amount changes, this item will be revised.

D. ____ The following percentage of the following standard that is not greater than the standards above: % of standard.

E. ____ The following formula is used to determine the amount:

F. ____ Other

G. ____ Not applicable (N/A)

a. ____ Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2. ____ The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)____ SSI Standard

(b)_____ Medically Needy Standard

(c)______ The special income level for the institutionalized

(d)_____ The following percent of the Federal poverty level:

% **

(e)_____ The following dollar amount

$ **

**If this amount changes, this item will be revised.

STATE: __________________________ -27- DATE: __________________________
(f) The following formula is used to determine the needs allowance:

(g) Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.
APPENDIX D
ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATIONS OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations)- of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

___ Discharge planning team
___ Physician (M.D. or D.O.)
___ Registered Nurse, licensed in the State
___ Licensed Social Worker
___ Qualified Professional, as defined in 42 CFR 483.430(a)
___ Other (Specify):
APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

_____ Every 3 months
_____ Every 6 months
__X__ Every 12 months
_____ Other (Specify):

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

_____ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

___ Physician (M.D. or D.O.)
___ Registered Nurse, licensed in the State
___ Licensed Social Worker
__X__ Qualified Professional, as defined in 42 CFR 483.430(a)
___ Other (Specify):

STATE: _______________________ -30- DATE: ________________
C. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_____ "Tickler" file

_____ Edits in computer system

_____ Component part of Case Management Service Coordination

_____ Other (specify): Component part of County MH/MR Program responsibility and review in accordance with grant agreement with the Department and a component part of Regional Office of Mental Retardation reviews.
APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

   ___ By the Medicaid agency in its central office
   ___ By the Medicaid agency in district/local offices
   ___ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program
   ___ By the case managers
   ___ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations
   ___ By service providers
   ___ Other (Specify):
       The responsible MH/MR Program or its designee, the service coordination unit.

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment criteria to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.
Check one:

[X] The process for evaluating and screening diverted individuals is the same as that used for deinstitutionalized persons.

___ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.
ATTACHMENT TO DEFINITION OF LEVEL OF CARE ELIGIBILITY

1. LEVEL OF CARE ELIGIBILITY

Each individual who receives home and community services funded under this 1915 (C) Waiver must be eligible for ICF/ORC level of care according to criteria established by the Department and approved by the Health Care Financing Administration (HCFA).

The criteria for an ICF/ORC level of care for infants and toddlers until the age of three are as follows:

Ia. A licensed psychologist, certified school psychologist, psychiatrist, or licensed physician who practices psychiatry to certify that the applicant or recipient has significantly sub-average intellectual functioning which is documented by either:

i) Performance which is more than two standard deviations below the mean of standardized general intelligence test; or

ii) Performance which is slightly higher than two standard deviation below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.

OR

Ib. A qualified professional shall certify that the applicant or recipient has other related conditions as defined by 42CFR435.1009 that include cerebral palsy and epilepsy, as well as other conditions, such as autism, other than mental illness, that results in impairments of general intellectual functioning or adaptive behavior, and requires early intervention services and treatment.

AND

II. A qualified professional who meets criteria established in 42 CFR 483.430 certifies that the applicant or recipient has impairments in adaptive behavior as provided by an assessment of adaptive functioning which shows that the individual has one of the following:

STATE: _______________________ -34- DATE: ___________
i) Significant limitations in meeting the standards of maturation, learning, personal independence, and or social responsibility of his or her age and cultural group evidenced by a minimum of a 50 percent delay in one or 33 percent delay in two of the following developmental areas:

   a. cognitive development
   b. physical development, including vision and hearing
   c. communication development
   d. social development
   e. adaptive development

   OR

ii) Substantial functional limitation in three or more of the following areas of major life activity:

   1. self-care
   2. receptive and expressive
   3. learning
   4. mobility
   5. self-direction
   6. capacity for language living
   7. economic self-sufficiency

   AND

III. The applicant's or recipient's conditions are likely to continue indefinitely for a period of at least 12 months.
APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR BEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:
   a. informed of any feasible alternatives under the waiver; and
   b. given the choice of either institutional or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 43 1, subpart E, to individuals who are not given the choice of home or community based services as an alternative to the institutional care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:
   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;
   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;
   c. A description of the State's procedures for allowing individuals to choose either institutional or home and community-based services; and
   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 43 1, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

The responsible County MH/MR Program

STATE: _____________________  -36-  DATE: _______________________

Revised 6/29/99
SCOPE:

County MH/MR Program Administrators
County Assistance Office Directors
Base Service Unit/Service Coordination Agency Directors

PURPOSE:

County MH/MR Program Administrators County Assistance Office Directors Base Service Unit/Service Coordination Agency Directors

To clarify procedures for determining eligibility and freedom of choice for early intervention services funded under the Department's Medicaid Waiver for Infants, Toddlers and Families.

BACKGROUND:

The Pennsylvania Department of Public Welfare has received approval from the Federal Health Care Financing Administration (HCFA) to provide early intervention services funded under a Medicaid Waiver for Infants, Toddlers and Families, effective July 1, 1998. Federal approval of this waiver is in accordance with Section 1915(c) of the Social Security Act.

As a condition of federal financial participation (FFP), infants and toddlers who receive services funded under the waiver must satisfy certain level of care and financial eligibility requirements. State assurances also provide families with certain rights to safeguard their freedom of choice and due process.

This bulletin establishes the Department's policy and procedures for County MH/MR Programs to follow in the determination of a child's eligibility for services funded under the waiver and in offering families information and choice in the receipt of waiver funded services.
The procedures established in this bulletin reflect comments and suggestions of the early intervention stakeholders including family representatives, providers, county MH/MR programs and advocates. It is the intention of the Department to implement these procedures in a manner which does not dilute or compromise the requirements for early intervention or confuse families with regard to their rights under various funding streams and programs. Waiver funding of services for the child should not have any effect on services or programs which are included in it child's Individualized Family Service Plan (IFSP), and must not interfere with the delivery of those services or programs. Participation in the waiver is completely optional to the extent that a family's choice not to receive waiver funded services can have no impact on what services the child receives on the IFSP.

DISCUSSION:

I. General Information

This bulletin is effective with eligibility determinations for waiver funding of IFSP services processed on and after July 1, 1998.

While the procedures described in this bulletin are complicated by the interface of Federal requirements for the waiver with other statutory requirements for early intervention, the procedures are, in theory, quite simple. Following the multi disciplinary evaluation (MDE) the child's IFSP is developed by an appropriately constituted team. If any of the services on the IFSP meet the requirements for the waiver and the family agrees to participate in the waiver, the family's County MH/MR Program determines whether the child meets the waiver's level of care requirements. If the child is determined to meet the level of care requirements and the family agrees to participate in the waiver, the County authorizes waiver funding for IFSP services based on its availability of waiver funds allocated by the Department. Annual recertifications are completed to assure that the child continues to be eligible for waiver funded services. Eligibility determinations are coordinated with the County Assistance Office (CAO). Throughout this whole process, family rights are preserved based on state assurances to the Federal government.

Like all other funding streams for early intervention, waiver funding supports only those services that are authorized in the child's Individualized Family Service Plan (IFSP). All time frames and other requirements related to the IFSP continue to be in effect with waiver funding, and are not altered by the waiver eligibility or freedom of choice assurances. To underscore the controlling nature of the IFSP in relationship to the waiver, the bulletin refers to waiver-funded IFSP services" or "waiver funding for IFSP services", whenever possible.

To be eligible for waiver funding for IFSP services, a child must:

1. be determined to need early intervention services which meet the definition of waiver funded habilitation services by the IFSP team, based on the child’s multidisciplinary evaluation (MDE).

2. be eligible for Medical Assistance as determined by the County Assistance Office (CAO).

3. meet the ICF/MR/ORC level of care criteria for the waiver, as determined by a qualified professional and the County MH/MR Program.
4. have waiver funded services explained to and chosen by the child's family or legal representative before waiver funded services are provided.

Even if a child meets the requirement to participate in the waiver, his or her family is free to decide not to participate. The child is still able to receive all of the services authorized on the IFSP funded through alternative funding streams, such as state, federal and county early intervention (EI) revenues, and, for children eligible for Medical Assistance, the Medicaid EI fee schedule.

The County MH/MR Program, through the service coordinator, is responsible to explain waiver funding for IFSP services to families only after the child's services in the IFSP are identified and it is determined that the child is likely to meet the level of care criteria for the waiver. The explanation includes a description of the nature and type of services being offered under the waiver, including the option of choosing waiver funded services with or without services funded by alternative sources.

The service coordinator should assure that the family understands that waiver funding can be provided for IFSP services which are offered in a clinic or in a center based program where children without disabilities are not in attendance, and that waiver funded IFSP services are provided in natural environments with the participation of the family or caregiver. The service coordinator is also responsible to assure that the family is advised of their rights under the waiver at this time, and to offer the family a choice of whether they want to receive waiver funding for IFSP services.

The waiver eligibility process must not delay development of the child's IFSP- or jeopardize compliance with other requirements of Part H (replaced by Part C, effective July 1, 1998) of the Individuals with Disabilities Education Act (IDEA). The County MH/MR Program is responsible to assure that any delays in service resulting from procedures contained in this bulletin are immediately corrected and reported to the Regional Office of Mental Retardation if they persist.

Eligibility for waiver funded IFSP services can be determined at any time before the child's third birthday. A child may be determined eligible for Waiver funding after the initial IFSP is developed or as a result of some additional evaluations or assessments once early intervention services funded under other means have been in place. Regardless of the time that eligibility is determined, waiver funding must be indicated on the child's IFSP before waiver funding can be authorized. All waiver eligibility determinations must be completed in consultation with the family and the service coordinator, with the approval of the family, and in a manner which does not jeopardize the timely provision of services in the IFSP.

Attachment 1 of this bulletin contains a County Information Summary. This summary outlines eligibility, choice and other waiver requirements, along with a description of the eligibility process and the roles of the various parties. The summary also contains a flow chart of possible early intervention funding tracks which are recommended as a basis for familiarizing families with waiver requirements, and for training of service coordinators and providers of service.

II. Initial Eligibility for Waiver Services

Before waiver funded IFSP services can be authorized, the Department must establish that the child satisfies financial and level of care eligibility requirements established by the
Department in its approved waiver application. Financial eligibility is based on the child’s eligibility for Medical Assistance which is determined by the CAO. Level of care eligibility is based on the determination by the County MH/MR Program.

A. Medical Assistance Eligibility

All children enrolled in the waiver must be eligible for Medical Assistance. Once a child's Medical Assistance eligibility is determined, no other financial eligibility forms for the waiver should be required for purposes of determining the child's initial eligibility for the waiver.

Children enrolled in SSI are automatically eligible for Medical Assistance and meet all financial eligibility requirements for waiver-funded services. Children eligible for Medical Assistance through Temporary Assistance for Needy Families (TANF) also meet the financial eligibility requirements for waiver.

Since application for Medical Assistance is voluntary, a family may choose not to enroll the child in Medical Assistance. Children who are not enrolled in Medical Assistance cannot receive waiver funding for IFSP services. However, other non-Medical Assistance funding sources for IFSP services can still be utilized.

If needed, the County MH/MR Program or the child's service coordinator can assist the family in obtaining a Medical Assistance application for the child. The application is titled ACCESS to Medical Assistance for Children, Pregnant Women and Their Families (PA 600-C).

Once eligibility for Medical Assistance is established, the child is financially eligible for a range of Medical Assistance funded services for infants and toddlers, including early intervention services funded through the Medicaid (MA/EI) fee schedule, and Early Periodic Screening, Diagnosis and Treatment (EPSDT).

The child's family is responsible for notifying the CAO of any changes that would affect the child's Medical Assistance eligibility, such as a new source of income for the child. The Department's notices regarding the child's Medical Assistance eligibility are issued by the CAO and are subject to the family's right to fair hearing and appeal before the Department of Public Welfare Bureau of Hearings and Appeals. Termination of the child's Medical Assistance benefits cannot affect the child's receipt of services authorized in the IFSP.

The family will be advised by the CAO regarding any condition of eligibility for Medical Assistance, including third party liability. The family has the option to refuse Medical Assistance eligibility for the child, have eligibility terminated, or decide either not to participate or to withdraw from the waiver. In any of these instances, advance notice is not provided and no appeal right is attached to the notice reflecting the recipient's request.

To prevent Medicaid from billing a liable third party and for the recipient to remain Medicaid eligible, the family or County can apply another source of payment to substitute for what the family's insurance plan may be liable to pay. This payment source can include early intervention funding allocated to the county by the Department. The County should not make waiver payments for amounts that would be covered by a third party liability assessed by the County Assistance Office.

As long as a child's Medical Assistance coverage is in force, there should be no need for any additional application or financial information to maintain eligibility for waiver funded IFSP services.
services except for the continued needs for the level of care in an ICF/MR/ORC. Families can apply for the child's Medical Assistance eligibility at any time and obtain further information or support in the Medical Assistance determination process by contacting the child's service coordinator.

Determination of the child's eligibility for Medical Assistance needs to precede eligibility waiver funded IFSP services, although applications for both waiver and Medical Assistance can be submitted to the CAO simultaneously.

B. Initial Level of Care Determination

Children who are eligible for Medical Assistance must meet specific ICF/MR/ORC level of care criteria to receive waiver funding for IFSP services. Attachment #2 contains a copy of the ICF/MR/ORC level of care criteria for this waiver and a Level of Care Information Sheet for Families, which applies to children who become eligible for this level of care based on a developmental delay.

The County MH/MR Program, through the service coordinator, is responsible to explain the waiver, including level of care eligibility criteria to the families only after services on the IFSP are identified and the service coordinator determines the child is likely to meet the level of care criteria. The service coordinator's determination to inform the family about the waiver is based on the review of services in the IFSP and screening, evaluation, and assessment information in the child's most current multidisciplinary evaluation (MDE).

When level of care eligibility is introduced to the family, the service coordinator is responsible to assure that the following additional information is also conveyed to the family:

- that waiver funded services in the IFSP must be provided in natural environments with the participation of the family and/or caregiver
- that other services in the IFSP may also be provided in natural environments with family or caregiver participation.
- that waiver funded services cannot be provided in an office, clinic or at a center based program where children without disabilities are not in attendance.
- that waiver funded IFSP services can be provided in conjunction with other early intervention services authorized on the IFSP.
- that the family's choice to receive waiver funding for IFSP services has no effect on the child's receipt of services in the IFSP which can be provided through alternate funding sources.
- that the final level of care eligibility determination is based on a qualified professional's review.
- the review will be based on existing information, unless the existing information is not adequate for the professional to render a determination.
After the family is informed of the ICF/MR/ORC level of care criteria and waiver funded services, the service coordinator is responsible to request the family's permission to complete a formal level of care determination for the child. If the family gives this permission, the service coordinator is responsible to assure that the appropriate screening, assessment and evaluation information is forwarded to complete this process.

If the family does not give its permission to complete the level of care determination, the service coordinator is responsible to advise the family that waiver funding will not be available under the IFSP, but that the child is still eligible to receive all of the services authorized on the IFSP through other funding streams.

If the family chooses not to have a level of care determination completed for the child, the service coordinator is also responsible to note the family's choice in the child's service coordination record.

The initial level of care determination can only be made by an independent Qualified Mental Retardation Professional, referred to as a Qualified Professional, who is approved by the County MH/MR Program and qualified based on meeting the requirements of 42 CFR 483.430 A copy of these requirements is contained as part of the County Information Summary in Attachment 1.

To be independent for the purposes of the initial determination, the Qualified Professional cannot be a provider of early intervention services for the child. A Qualified Professional who is a member of the child's initial MDE or IFSP team is considered independent only if the professional is not also a provider of the child's early intervention services. Any provider of IFSP services to the child, including the child's service coordinator or that service coordinator's supervisor, does not meet the independent professional requirements for this initial waiver eligibility determination.

The level of care determination must be based on current social; psychological and medical information presented to the independent Qualified Professional by the family, service coordinator, and/or MDE or IFSP team. Generally, no additional assessments or evaluations apart from those records provided through the IFSP development process should be required by the Qualified Professional for purposes of this determination.

Once the initial level of care determination is made, the Qualified Professional is responsible to immediately notify the County MH/MR Program of the determination by signing Form No. 123, titled: Certification of Need for Infants, Toddlers and Families Waiver. A copy of the form is contained in Attachment 43.

Once the signed Form No. 123 is received, the County MH/MR Administrator or designee verifies that the professional making this determination is qualified based on the Department's criteria, certifies the County's determination in the space provided on Form No. 123, and notifies the family whether the child meets the level of care criteria. Family notification can be made by the service coordinator by phone or at a meeting. Any designee signing the Form No. 123 must be a public employee of the County MH/MR Program. The County is responsible to retain a copy of the determination for a minimum of three years.

Once the determination on eligibility is shared with the family, the County MH/MR Program is responsible to assure that the service coordinator instructs the family to complete Form No. 456, regarding freedom of choice. When the family chooses waiver-funded services on
Form No. 456, County MH/MR Program forwards the initial level of care determination, Form No. 123, to the CAO. Form No. 456 should not be provided to the CAO. Additional information and requirements regarding freedom of choice are contained in Section IV.

Once the County MH/MR Program forwards the completed Form No. 123 to the CAO, the CAO is responsible to issue a notice of waiver eligibility based on the County MH/MR Program level of care determination. If the County determines that the child meets the level of care criteria for the waiver, the CAO issues notice that the child is eligible for waiver funded IFSP services. If the County MH/MR Program determines that the child does not meet the level of care criteria for the waiver, a waiver service denial notice is issued by the CAO to the family, together with instructions for filing a fair hearing and appeal. The County MH/MR Program is responsible for notifying the family's service coordinator and providers of services regarding the child's eligibility for purposes of recording waiver funding on the IFSP and provider billing. A notice that determines a child ineligible for waiver funded IFSP services does not affect the child's eligibility for other funding streams and cannot delay the provision of services in the IFSP.

The effective date on the notice from the CAO is the first date waiver funded IFSP services can be provided. The County MH/MR Program can request an effective date on the space provided on Form No. 123. FFP is not available for waiver services which are furnished prior to the level of care determination, the development of the IFSP (plan of care), and the date the family chooses waiver services on Form No. 456. The CAO notice of eligibility remains in force for 365 days from the effective date of service, unless repealed by a subsequent notice from the CAO or by the child reaching his/her third birthday.

All children become ineligible for waiver funding for IFSP services on and after their third birthday. The County MH/MR Program is responsible to notify the family 90 days prior to the child's third birthday that waiver funding will be discontinued, but that such discontinuance does not affect the continuation of services on the IFSP. Services on the IFSP after the third birthday may continue to be provided in accordance with Basic Education Circular titled: Early Intervention Transition: Infants and Toddlers to Preschool 11 P.S & 975-3 04, issued: September 1, 1997. A notice of discontinuance for waiver service will also be sent to the family by the CAO within 30 days of the child's third birthday, with a copy to the County MH/MR Program.

III. Recertification of Level of Care Eligibility

Each child's level of care eligibility must be recertified at least once annually for the child to continue to be eligible for waiver funded IFSP services. The County MH/MR Program is responsible to assure that this recertification process occurs in conjunction with the child's annual IFSP review, whenever possible.

The County MH/MR Program is responsible to assure that the level of care recertification is completed by a Qualified Professional, who is approved by the County MH/MR Program. For purposes of this recertification process only, the Qualified Professional may be the child's service coordinator, an independent professional who completes the MDE or a member from the IFSP learn who is not a provider of waiver funded IFSP services or an employee of a provider agency that renders services on the IFSP. The Qualified Professional bases the determination on whether the child continues to meet the level of care criteria contained in Attachment #2. The determination of the Qualified Professional is based on review of the child's most current MDE and IFSP and an evaluation of the child's current condition.
The Qualified Professional completes the applicable portion of Form No. 123-A and forwards the form to the County MH/MR Program. The County MH/MR Program Administrator, or designee, signs Form No. 123-A and maintains a copy of the form on record for a minimum of three years. The county designee must be a public employee of the County MH/MR Program. A copy of Form No. 123-A is contained in Attachment #3.

No notice of continuing eligibility is sent to the family based on the recertification by the County MH/MR Program. If the child is determined to no longer meet the level of care requirements, the County NUVMR Program is responsible to notify the CAO, which will, in turn, issue an advance notice to discontinue waiver funded services to the family with a notice of the family's right to Department fair hearing and appeal. A copy of the advance notice will be sent to the County MH/MR Program. The County MH/MR Program is responsible to advise the family's service coordinator and providers of service regarding a change in the child's eligibility for purposes of recording waiver funding on the IFSP and provider billing. If the family files a timely appeal, the county is authorized to continue waiver funded IFSP services until the Department's decision is made through the Office of Hearings and Appeals. Instructions on fair hearing and appeal procedures are contained as part of Form No. 456-A, in attachment 5.

A review to determine that a child continues to qualify for waiver funded services can be authorized by the County MH/MR Program at any time, based on information warranting such a review, including a recommendation from the family, the service Coordinator or the IFSP team.

IV. Freedom of Choice

Families are assured of certain information and due process rights under the waiver. These rights are in addition to rights afforded under other Federal and state funding streams, including EPSDT, and Act 212. The County MH/MR Program is responsible for notifying the family regarding their rights under the various programs and funding-streams and will provide assistance to families in filing due process, fair hearings and appeals.

A. Waiver Information and Choice

Under the waiver, a family has the right to be informed of feasible home and community service alternatives for the child, and to be offered a choice between waiver services or services in an ICF/MR/ORC.

The service coordinator is responsible to inform the family about the waiver along with other feasible funding and program alternatives in the home and community, and to offer the family the choice of receiving waiver funded IFSP services, non-waiver funded IFSP services, or services in an ICF/MR/ORC. Before the family is offered the choice of services, the service coordinator is responsible to assure that the family is informed:

- about other feasible funding alternatives for the child, such as EPSDT, and county funded early intervention.

- that services authorized in the child's IFSP will not be affected by the family's choice to receive or not receive waiver-funded services.

- that waiver funded IFSP services can be authorized in conjunction -with other services the. child needs as part of the IFSP. Other services can be funded through
- other funding streams, such as federal, state and county early intervention revenues and the MAIM Fee Schedule.

- that waiver funded IFSP services must occur in natural environments and with the participation of the family or caregiver.

- that the family can change their choice to receive or not receive waiver funded IFSP services at any time

In order to satisfy Federal funding requirements, the service coordinator must be prepared to explain intermediate care in an ICF/MR/ORC to the family.

Families must **sign** that they choose waiver funded services for their child before waiver funding for IFSP services can be authorized. This choice is offered only when services on the IFSP are developed and the service coordinator determines that the child is likely to qualify for level of care, based on the IFSP and MDE.

The family's choice must be certified *on* Form No. 456 by the child's parent or legal representative. The legal representative can be the child's surrogate parent as provided under Part H/Part C of IDEA. The County MH/MR Program is responsible to provide the family with a copy of the signed Form No. 456, retain a copy of the family's signed choice Form No. 456 for a minimum of three years, and provide any additional information about the family's right to Department hearing and appeals that the family may request.

**B. Due Process Rights**

Under the waiver, the service coordinator is responsible to inform families about their due process right to fair hearing and appeal before the Department's Bureau of Hearings and Appeals whenever the family:

1. is not informed of feasible home and community alternatives for the child, including waiver funded IFSP services.

2. is not given the choice of waiver funded IFSP services or ICF/MR/ORC for the child.

3. is denied waiver funded service(s) of their choice for the child.

4. is denied a waiver funded provider of their choice for the child.

A family's right to due process includes the right to appeal any action or failure to act if the family is dissatisfied with any decision to refuse, suspend, reduce or terminate waiver funded IFSP services. Non-Medicaid funded IFSP services cannot be appealed through this process.

The family's appeal rights and instructions for filing an appeal are contained under Form No. 456 A. A copy of this material is included in Attachment 45. The County MH/MR Program is responsible to provide the family with a copy of Form No. 456 A, and to retain a copy of appeals for a minimum of three years.
The County NUVMR Program is responsible to participate in any fair hearing regarding any determination of level of care or services. The service coordinator or other County MH/MR Program designee, on request of the family, will assist the family in filing for fair hearing.

If preservation of waiver service eligibility and funding is at issue, Departmental appeal and fair hearing procedures contained in this bulletin should be pursued first. Any Medicaid funded service appeal must be made through the Department's hearing and appeal process. It is recommended that individual child and family circumstances prevail in decisions of selecting which, if any, appeals may work best.

V. Process Outline

The following outline summarizes major steps in the eligibility and freedom of choice process for this waiver. Variations in the process can be expected based on individual circumstances. These areas Rye to be explained in greater detail as part of training and orientation.

1. Early Intervention Process
   a. Child is referred to County NUVMR Program for intake and is assigned a service Coordinator.
   b. Child receives MDE which determines need for early intervention.
   c. Services in the IFSP are identified.
   d. EI services begin.

2. Medical Assistance Determination
   a. The child is referred to the CAO for a determination of eligibility for Medical Assistance.
   b. The family completes a Medical Assistance (MA) ACCESS application for the child.
   c. The CAO determines whether the child is eligible for MA and issues a notice of eligibility to the family.

3. Initial Eligibility for Waiver Funded IFSP Services
   a. The service coordinator identifies the child as being likely to qualify for the ICF/MR/ORC level of care based on DPW criteria.
   b. The service coordinator explains level of care eligibility criteria to the family and obtains permission to submit screening, evaluation, and/or assessment information to a Qualified Professional for determination of level of care eligibility.
c. The Qualified Professional completes a determination on level of care by signing the first portion of the eligibility determination form (Form No.* 123), and forwards this form to the County MH/MR Program.

d. The County MH/MR Program issues its eligibility determination on the lower portion of Form No. 123 and authorizes the service coordinator to advise the family regarding the determination.

e. The service coordinator advises the family and requests that the family declare the choice of services by signing Form No. 456.

f. When the family chooses waiver funding for IFSP services on Form No. 456, the service coordinator notifies the County MH/MR Program which ensures that the Form No. 123 is forwarded to the CAO. The County MH/MR Program indicates an effective date on Form No. 123, if applicable. The effective date and FFP cannot precede dates of the level of care determination, the development of the IFSP, and the family's choice to receive waiver services for the child.

g. The CAO issues a notice of waiver eligibility to the family (Form MA 162) copying the County MH/MR Program.

h. The County MH/MR Program advises the service coordinator and providers of service regarding the effective date of waiver eligibility for purposes of the IFSP and provider billing.

i. Waiver funded services are indicated on the IFSP and providers begin delivering waiver funded services.

4. Annual Recertification

a. A Qualified Professional evaluates to determine whether the child continues to meet ICF/MR/ORC level of care eligibility criteria based on the most current MDE and IFSP; completes the first portion of the annual recertification Form No. 123-A; and forwards it to the County NUVMR Program.

b. The County NUVMR Program certifies whether the child continues to be eligible for waiver funding for IFSP services and files the completed Form No. 123-A. Family and provider notification is not required unless the child no longer meets eligibility criteria.

c. If the child is determined to no longer be eligible for waiver funded IFSP services, the County MH/MR Program notifies the CAO which issues an advance notice to the* family to discontinue waiver funded IFSP services, along with a notice of the family's right to due process.

d. The County NUVMR Program advises the service coordinator and providers regarding changes in the child's funding status.
e. The County MH/MR Program sends a notice to the family regarding discontinuance of waiver funding 90 days prior to the child's third birthday.

f. The CAO sends a notice to the family regarding discontinuance of waiver funding at least 30 days prior to the child's third birthday, along with any applicable appeal rights.
MEDICAID WAIVER FOR INFANTS, TODDLERS & FAMILIES

County MH/MR Program Information Summary

I. State Requirements/Waiver Assurances

A. Eligibility

The Department of Public Welfare assures HCFA that only infants and toddlers up to the age of three who meet the level of care eligibility criteria for care in an ICF/MR or ICF/ORC are eligible for waiver funding for IFSP services. The Department also assures that all children meet eligibility requirements for Medical Assistance and need early intervention services.

The approved waiver application assures that the Department will provide for an evaluation and periodic reevaluations of the need for the level of care indicated in the waiver request when there is a reasonable indication that individuals might need such services in the near future. Under this waiver request, the initial evaluation of level of care must be conducted by a Qualified Mental Retardation Professional, referred to as a Qualified Professional, as defined in 42 CFR 433.430. Reevaluations must also be completed by a Qualified Professional every 12 months. The Department also assures that the County MH/MR Program will be responsible to maintain records of evaluations and reevaluations and assure that evaluations/reevaluations will be done in a timely fashion.

Written documentation of all evaluations and reevaluations will be maintained for a minimum period of three years.

B. Rights and Due Process

The Department of Public Welfare assures HCFA of certain individual and family rights, as a condition of Federal financial participation under the waiver. The Department assures that when an individual is determined likely to require a level of care indicated in its approved waiver request, the individual or his/her legal representative will be:

a. informed of any feasible alternatives under the waiver; and

b. given the choice of either institutional or home and community-based -services.

The Department also assures that it will provide an opportunity for a fair hearing under Federal requirements (42 CFR Part 43 1, subpart E) to individuals who are not given the choice of home or community-based services as an alternative to the Institutional care for the level of care indicated in the approved waiver request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

As part of this assurance, the Department must include the following items in its approved waiver application:
1. a copy of the forms used to comment on freedom of choice and to offer a fair hearing;

2. a description of the agency's procedures for informing eligible individuals (or their legal representatives) of feasible alternatives available under the waiver;

3. A description of the state's procedures for allowing individuals to choose either institutional or home and community-based services; and

4. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under Federal requirements (42 CFR Part 431, subpart E).

II. Outline of Related Processes

The following outline summarizes major steps in the eligibility and freedom of choice process for this waiver. Variations in the process can be expected based on individual circumstances. These areas are to be explained in greater detail as part of training and orientation.

1. Early Intervention Process
   a. Child is referred to County NUVMR Program for intake and is assigned a service Coordinator.
   b. Child receives MDE which determines need for early intervention.
   c. Services in IFSP are identified.
   d. EI services begin.

2. Medical Assistance Determination
   a. The child is referred to the CAO for a determination of eligibility for Medical Assistance.
   b. The family completes a Medical Assistance (ACCESS) application for the child.
   c. The CAO determines whether the child is eligible for Medical Assistance and issues a notice of eligibility to the family.

3. Initial Eligibility for Waiver Funded IFSP Services
   a. The service coordinator identifies the child as being likely to qualify for ICF/MR/ORC level of care based on DPW criteria.
   b. The service coordinator explains waiver funding and level of care eligibility criteria to family and obtains permission to submit screening, evaluation, and assessment information to a Qualified Professional for determination of waiver eligibility.
c. The Qualified Professional completes first portion of waiver eligibility determination form (Form No. 123) and forwards to County NUVMR Program for final certification.

d. The County MH/MR Program certifies the Qualified Professional's waiver eligibility determination on Form No. 123 and authorizes the service coordinator to advise the family regarding the determination.

e. The service coordinator advises the family regarding the child's level of care determination and requests that the family signify their choice to receive waiver funded IFSP services, or ICF/MR/ORC by signing Form ,No. 456.

f. When the family chooses waiver funding for IFSP services on Form No. 456, the service coordinator notifies the County MH/MR Program which ensures that the Form No. 123 is forwarded to the CAO. The County Assistance Office indicates an effective date on the Form No. 123, if applicable. The effective date and FFP cannot precede the dates of the child's waiver eligibility determination, the development of the IFSP. And the family's choice to receive waiver services for the child.

g. The CAO issues a notice of waiver eligibility to the family, copying the County MH/MR Program.

h. The County MH/MR Program advises the service coordinator and providers of service regarding the effective date of waiver eligibility for purposes of the IFSP and provider billing.

i. Waiver funded services are indicated an IFSP and providers begin providing waiver funded IFSP services.

4. Annual Recertification

a. A Qualified Professional evaluates to determine whether the child continues to meet level of care eligibility criteria based on information available at the time of the re-determination; completes the first portion of the recertification form, Form No. 123-A, and forwards the signed form to the County MH/MR Program.

b. The County MH/MR Program certifies whether the child continues to be eligible for waiver funding for IFSP services and files the completed Form No. 123-A. Family and provider notification is not required unless there is a change from the initial determination of the child's eligibility except for the continued need for the level of care provided in an ICF/MR/ORC.

c. If the child is determined to no longer be eligible for waiver funded IFSP services, the County NUVMR Program notifies the CAO which issues an advance notice to the family to discontinue waiver funded IFSP services, along with a notice of the family's right to due process.

d. The County MH/MR Program advises the service coordinator and providers regarding changes in the child's funding status.
e. The County MH/MR Program sends a notice to the family regarding discontinuance of waiver funding 90 days prior to the child's third birthday.

f. The CAO sends a notice to the family regarding discontinuance of waiver funding 30 days prior to the child's third birthday.

III. Roles

1. Family

   a. Chooses to apply for child's Medical Assistance.

   b. Participates in MDE and in developing IFSP.

   c. Chooses whether child undergoes level of care determination for waiver funded services.

   d. Chooses whether to agree to participate in waiver as a source of funding in the IFSP.

   e. Participates with provider in the provision of waiver services.

   f. Files fair hearing and appeal if freedom of choice assurances are not met to family's satisfaction.

2. Service Coordinator

   a. Assists family in applying for the child's Medical Assistance, if requested by the family.

   b. Participates in MDE and IFSP.

   c. Informs family about waiver funding for IFSP services, including information about family rights and waiver eligibility process.

   d. Assures with the family's permission, that current MDE and IFSP information is provided to the Qualified Professional for purposes of the waiver eligibility determination and recertification.

   e. Assures that the family signifies their choice to receive waiver funding for IFSP services, non-waiver funded IFSP services or ICF/MR/ORC; and forwards the completed Form No. 456 to the County NUVMR Program.

3. Qualified Professional

   a. Determines with the family's permission whether the child meets level of care eligibility; completes first portion of Form No. 123; and forwards determination to the County MH/MR Program.

   b. Determines annually whither the child continues to meet waiver eligibility criteria; completes portion of annual recertification Form No. 123-Â; and forwards determination to the County MH/MR Program.
4. County MH/MR Program

   a. Completes County MH/MR portion of waiver level of care determination Form No. 123.

   b. Assures that the family is advised regarding the level of care determination and has chosen waiver funded IFSP services, or ICF/MR/ORC, in accordance with department procedures.

   c. Forwards completed level of care determination, Form No. -123, to CAO for notice -waiver eligibility.

   d. Advises service coordinator and providers of service regarding level of care determination for purposes of the IFSP and provider billing.

   e. Assures waiver funding is available before authorizing services.

   f. Assures annual recertification of level of care is completed every 12 months, and signs appropriate portion of Form No. 123-A.

   g. Notifies CAP if child is determined to no longer be eligible for waiver funded IFSP services.

   h. Retains level of care and freedom of choice documentation for at least three years.

   i. Offers training to service coordinators and providers, informs families; assures Department requirements are met; corrects problems, and advises the Regional Office of Mental Retardation regarding issues and concerns.

   j. Attends fair hearings and appeals regarding determinations of level of care or services.

5. CAO

   a. Determines Medical Assistance eligibility for the child.

   b. Notifies family of child's eligibility for Medical Assistance.

   c. Upon receipt of Form No. 123 or From No. 123-A indicating eligibility for waiver services, issues notices of waiver eligibility, suspensions and denials, with notice of family right to due process.

   d. Issues notice of discontinue of waiver funded IFSP service to family and County MH/MR Program.

   e. Indicates effective date of waiver eligibility on Form No. 123, as appropriate.
How do the decisions around Early Intervention funding flow?

1. Child referred for early intervention
   - M.D.E completed
   - I.F.S.P. supports & services identified and written
     - If No: If Not Eligible for Waiver
     - If Yes: If Eligible for Waiver

2. Resources to Support I.F.S.P.
   - State Early Intervention funds
   - County funds
   - Social Service Block Grants
   - Part C (IDEA) funds
   - Private insurance
   - Private contributions
   - Community resources

3. Family decides whether child will have Level of Care determination for
   - MH/MR determines Level of Care eligibility for Waiver funded services
     - If Not Eligible for Waiver
     - If Eligible for Waiver

4. Resources to Support I.F.S.P.
   - (all of the above, plus)
     - Traditional Medicaid
     - EPSDT
     - FI MA

5. Resources to Support I.F.S.P.
   - (all listed in the above two boxes, plus)
     - Infant, Toddler & Family Waiver

6. County MH/MR authorizes Waiver funded I.F.S.P. services
7. C.A.O. issues Notice of Waiver Eligibility (Form 162)
8. MH/MR forwards Form 123 to C.A.O.

Revised: 21 May 1998
Level of Care Criteria Under Medicaid Waiver for Infants, Toddlers and Families

The criteria for an ICF/MR or ICF/ORC level of care for infants and toddlers until the age of three are as follows:

I.a. A licensed psychologist, certified school psychologist or a licensed physician shall certify that the applicant or recipient has significantly subaverage intellectual functioning which is documented by one of the following:

(i) Performance that is more than two standard deviations below the mean as measurable on a standardized general intelligence test.

(ii) Performance that is slightly higher than two standard deviations below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.

OR

I.b. A qualified professional shall certify that the applicant or recipient has other related conditions as defined by 42 CFR 435.1009 that include cerebral palsy and epilepsy, as well as other conditions -such as autism - other than mental illness - that result in impairments of general intellectual functioning or adaptive behavior, and require early intervention services and treatment.

AND

II. A qualified professional as defined in 42 CFR 483.430 certifies that the applicant or recipient has impairments in adaptive behavior as provided by an assessment of adaptive functioning which shows that the applicant or recipient has one of the following:

(i) Significant limitations in meeting the standards of maturation, learning, personal independence, or social responsibility of his/her age and cultural group evidenced by a minimum of a 50 percent delay in one or 33 percent delay in two of the following developmental areas:
a. cognitive development  
b. physical development, including vision and hearing  
c. communication development  
d. social and emotional development  
e. adaptive development  

OR

(ii) substantial functional limitation in three or more of the following areas of major life activities:

a. self-care  
b. receptive and expressive language  
c. learning  
d. mobility  
e. self-direction  
f. capacity for independent living  
g. economic self-sufficiency  

AND

III. The applicant's or recipient's conditions are likely to continue indefinitely for a period of at least 12 months.
Criteria for the level of care for infants and toddlers, age birth to three, to qualify for services under the Medicaid Waiver for Infants, Toddlers and Families are as follows:

1. A qualified professional shall certify that the applicant or recipient has other related conditions as defined by 42 CFR 435.1009 that include cerebral palsy and epilepsy, as well as other conditions - such as autism - other than mental illness - that result in impairments of general intellectual functioning of adaptive behavior, and requires early intervention services and treatment.

AND

2. A qualified professional as defined in 42 CFR 483.430 certifies that the applicant or recipient has impairments in adaptive behavior as provided by an assessment of adaptive functioning which shows that the applicant or recipient has a significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of his/her age and cultural group evidenced by a minimum of a fifty percent (50%) delay in one or thirty-three percent (33%) delay in two of the following developmental areas:

   a. cognitive development
   b. physical development, including vision and healing
   c. communication development
   d. social and emotional development
   e. adaptive development

AND

3. The applicant's or recipient's conditions are likely to continue indefinitely for a period of at least 12 months.
FORMS FOR CERTIFICATION AND RECERTIFICATION OF NEED FOR INFANTS, TODDLERS AND FAMILIES WAIVER

FORM NOS. 123 AND 123-A
CERTIFICATION OF NEED FOR INFANTS, TODDLERS & FAMILIES WAIVER

PURPOSE: THIS FORM IS TO CERTIFY WHETHER THE FOLLOWING NAMED INDIVIDUAL REQUIRES THE ICF/MR/ORC LEVEL OF CARE FOR DETERMINING ELIGIBILITY FOR THE MEDICAID WAIVER FOR INFANTS, TODDLERS & FAMILIES.

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I. QUALIFIED PROFESSIONAL CERTIFICATION (COMPLETE SECTION A IF THE INDIVIDUAL MEETS ICF/MR/ORC LEVEL OF CARE CRITERIA REQUIRED FOR WAIVER FUNDED IFSP SERVICES OR SECTION B IF THE INDIVIDUAL DOES NOT).

I HEREBY CERTIFY THAT THIS INDIVIDUAL:

- HAS COMPLETED ALL SCREENINGS, EVALUATIONS AND/OR ASSESSMENTS NECESSARY TO DETERMINE NEED FOR THE ICF/MR/ORC LEVEL OF CARE ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE FOR ENROLLMENT IN THE MEDICAID WAIVER FOR INFANTS, TODDLERS & FAMILIES.

and

A. NEEDS ICF/MR/ORC LEVEL OF CARE BASED ON CRITERIA ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE.

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or

B. DOES NOT NEED ICF/MR/ORC LEVEL OF CARE BASED ON THE CRITERIA ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE.

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II. DETERMINATION BY THE DEPARTMENT OF PUBLIC WELFARE DESIGNEE, THE COUNTY MH/MR PROGRAM, COUNTY MH/MR PROGRAM NAME:

- THIS INDIVIDUAL IS DETERMINED TO REQUIRE ICF/MR/ORC LEVEL OF CARE.

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- THIS INDIVIDUAL IS NOT DETERMINED TO REQUIRE ICF/MR/ORC LEVEL OF CARE

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MH/MR PROGRAM USE ONLY: WAIVER EFFECTIVE DATE REQUEST:

CAO USE ONLY: FAC CODE: DATE:

70
PURPOSE: THIS FORM IS TO CERTIFY WHETHER THE FOLLOWING NAMED INDIVIDUAL REQUIRES THE ICF/MR/ORC LEVEL OF CARE FOR DETERMINING ELIGIBILITY FOR THE MEDICAID WAIVER FOR INFANTS, TODDLERS & FAMILIES.

I. QUALIFIED PROFESSIONAL CERTIFICATION (COMPLETE SECTION A IF THE INDIVIDUAL MEETS ICF/MR/ORC LEVEL OF CARE CRITERIA REQUIRED FOR WAIVER FUNDED IFSP SERVICES OR SECTION B IF THE INDIVIDUAL DOES NOT).

I HEREBY CERTIFY THAT THIS INDIVIDUAL:

HAS COMPLETED ALL SCREENINGS, EVALUATIONS AND/OR ASSESSMENTS NECESSARY TO DETERMINE NEED FOR THE ICF/MR/ORC LEVEL OF CARE ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE FOR ENROLLMENT IN THE MEDICAID WAIVER FOR INFANTS, TODDLERS & FAMILIES.

and

A. NEEDS ICF/MR/ORC LEVEL OF CARE BASED ON CRITERIA ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE.

______________________________________________________ _________________________
SIGNATURE     DATE

______________________________________________________ _________________________
ADDRESS       TELEPHONE NUMBER

or

B. DOES NOT NEED ICF/MR/ORC LEVEL OF CARE BASED ON THE CRITERIA ESTABLISHED BY THE DEPARTMENT OF PUBLIC WELFARE.

______________________________________________________ _________________________
SIGNATURE     DATE

______________________________________________________ _________________________
ADDRESS       TELEPHONE NUMBER


THIS INDIVIDUAL IS DETERMINED TO REQUIRE ICF/MR/ORC LEVEL OF CARE.

_____________________________________________________ _________________________
COUNTY MH/MR PROGRAM SIGNATURE                  TELEPHONE NUMBER

THIS INDIVIDUAL IS NOT DETERMINED TO REQUIRE ICF/MR/ORC LEVEL OF CARE

_____________________________________________________ _________________________
COUNTY MH/MR PROGRAM SIGNATURE                  TELEPHONE NUMBER

MH/MR PROGRAM USE ONLY: ___________________ WAIVER EFFECTIVE DATE REQUEST: ____________________

CAO USE ONLY: ___________________ FAC CODE: ___________________ DATE: ____________________

Attachment 4
CERTIFICATION OF CHOICE
INFANTS, TODDLERS & FAMILIES MEDICAID WAIVER

I. Confirmation That Information About Choice is Provided

I, __________________________________________________, have been informed:
  FAMILY OR LEGAL REPRESENTATIVE OF INFANT OR TODDLER
  a. that my child has been determined likely to qualify for waiver funding for some or all of the services authorized
     in the child's individualized family services plan (IFSP).
  b. about feasible home and community based service alternatives, including services funded under the Medicaid
     Waiver, EPSDT, the EI-MA let schedule and other state/county funded early intervention.
  c. about my right to indicate a choice for home and community services funded under the Medicaid waiver or
     ICF/MR/ORC
  d. about my right to a Medicaid fair bearing and appeal 1.

In designating my choice for services:
  a. I acknowledge that home and community service alternatives have been explained to my satisfaction, including
     waiver funding for IFSP services
  b. I understand that waiver funded service(s) will only be available to the extent that they are needed based on my
     child's IFSP.

I understand that my child will receive the services in the IFSP, regardless of whether I choose to participate in the
waiver.
  d. I understand that some of the services in the IFSP can be funded through the waiver, and that other services can
     be funded through other funding streams, but that in any case, my child must receive all the early intervention
     services authorized in the IFSP.

II. Designation of service Choice

My service choice is: (check one only)

☐ I choose to participate in the waiver.
☐ I choose ICF/MR/ORC for my child.

III. Participant Information and Signatures

<table>
<thead>
<tr>
<th>INFANT/TODDLER NAME:</th>
<th>ADDRESS:</th>
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<tbody>
<tr>
<td>ACCESS NUMBER:</td>
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<tr>
<td>PARENT, FAMILY OR LEGAL REPRESENTATIVE NAME:</td>
<td>ADDRESS:</td>
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<td>SIGNATURE:</td>
<td>TELEPHONE NUMBER:</td>
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<td>DATE:</td>
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<td>COUNTY MH/MR DESIGNEE NAME:</td>
<td>ADDRESS:</td>
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<td>SIGNATURE:</td>
<td>TELEPHONE NUMBER:</td>
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<td>TITLE:</td>
<td>TELEPHONE NUMBER:</td>
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FORMS FOR FAIR HEARING REQUEST FOR INFANTS, TODDLERS AND FAMILIES MEDICAID WAIVER

FORM NO. 456-A
MEDICAID WAIVER FOR INFANTS, TODDLERS AND FAMILIES
NOTICE OF OPPORTUNITY FOR FAIR HEARING

To: Family Member

You have the right to a fair bearing and appeal before the Department of Public Welfare, Bureau of Hearings and Appeals if your child is likely to need the level of care specified in the Department's Medicaid Waiver for Infants, Toddlers and Families.

You have the right to a fair bearing and appeal if any of the following has occurred.

1. You have not been given information about the waiver, including information on how to become enrolled.
2. You have not been given the choice to have a determination of your child's level of care.
3. You have not been given the choice to receive waiver funded IFSP services or ICF/MR/ORC
4. You have been denied waiver-funded IFSP services of your choice.
5. You have been denied a waiver-funded provider of your choice, or you are dissatisfied with a decision to refuse, suspend, reduce or terminate IFSP services for your child that are funded under the Medicaid waiver.

If you want to file an appeal, please refer to further instructions on the back of this form and complete and mail the attached Form No. 456-A to:

Bureau of Hearings and Appeals
P.O. Box 267S
Harrisburg, Pennsylvania 17105-267S
Telephone Number: 717-793-3950
Fax Number: 717-772-2769

NOTE- IF SERVICES ARE AUTHORIZED IN THE CHILD'S CURRENT IFSP, THE FAMILY DOES NOT NEED TO APPEAL TO PRESERVE THOSE SERVICES.

REMINDER: YOUR APPEAL MUST BE FILED WITHIN 30 DAYS OF YOUR NOTIFICATION OF THE DECISION OR ACTION. IF YOU ARE APPELLING A DECISION TO REDUCE, SUSPEND OR TERMINATE ELIGIBILITY OR WAIVER FUNDED SERVICES, YOU MUST FILE YOUR APPEAL WITHIN 10 DAYS FOR WAIVER FUNDED SERVICES OR ELIGIBILITY TO CONTINUE PENDING THE APPEAL DECISION.
INFORMATION ABOUT HEARINGS AND APPEALS

Families of infants and toddlers with serious disabilities have rights to information, choice and services under the Medicaid Waiver for Infants, Toddlers and Families.

To find out more about the waiver and your rights, please contact your service coordinator.

If you want to file an appeal, please complete the Form No. 456-A and refer to the following information:

1. The hearing officer will notify you of the hearing date.

2. You may have a hearing over the telephone or face to face. Please complete this section of the form to express your preference.

3. If you do not have a phone, you can arrange to use a phone of the County MH/MR Program or of a friend, relative or neighbor.

4. You will not be granted a hearing if the action being appealed was solely caused by state or federal law regulation or policy, requiring a change in the type of services available to the infant or toddler.

5. At a hearing, you will have the opportunity to testify before the hearing officer and present evidence and provide a witness to support your appeal.

6. You can represent yourself at a hearing, or have anyone else represent you.

7. You may have an interpreter or other accommodations you need. Be sure to indicate what you need on Form No. 456-A.

8. You have the right to a conference with the County MEIMR Program to discuss your concern before filing your appeal and before your appeal is taken if you contact your service coordinator within 10 days of being notified of the decision. If you are dissatisfied with the results of this conference, you retain your right to a fair hearing with the Department if you file your appeal within 10 days of your meeting with the County MH/MR Program.

9. Your appeal must be filed within 30 days of the decision at action being taken. If you are appealing a decision to reduce, suspend or terminate eligibility or waiver funded services, you must file your appeal within 10 days of the decision to continue pending the appeal decision.
TO: DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF HEARINGS AND APPEALS  
P.O. BOX 2675  
HARRISBURG, PENNSYLVANIA 17105-2675  

CC: COUNTY MH/MR PROGRAM NAME: SPECIFY ____________________________________________  

FR: _____________________________________________________________  
NAME OF INDIVIDUAL/LEGAL REPRESENTATIVE  
__________________________________________________________  
MAILING ADDRESS  

__________________________________________________________  
DAY PHONE  
FAX NUMBER  

I HEREBY REQUEST AN OPPORTUNITY FOR FAIR HEARING BEFORE THE DEPARTMENT OF PUBLIC WELFARE BUREAU OF HEARINGS AND APPEALS. I UNDERSTAND THAT REGARDLESS OF WHETHER I FILE THIS REQUEST, MY CHILD IS ENTITLED TO RECEIVE SERVICES AUTHORIZED IN THE IFSP. AND THAT THOSE SERVICES WILL BE FUNDED USING NON-WAIVER REVENUES, INCLUDING MEDICAL ASSISTANCE, IF MY CHILD CONTINUES TO QUALIFY FOR MEDICAL ASSISTANCE.  

NAME OF INFANT OR TODDLER RECEIVING SERVICES: _________________________________________  

ACCESS NUMBER OF INFANT OR TODDLER: ___________________________________________________  

I AM APPEALING THE FOLLOWING ACTION: ___________________________________________________  
_________________________________________________________________________________________  
_________________________________________________________________________________________  
_________________________________________________________________________________________  

PLEASE CHECK ONE OF THE ITEMS BELOW TO INDICATE THE TYPE OF HEARING YOU WANT:  
☐ I WANT A TELEPHONE HEARING  
☐ I WANT A FACE TO FACE HEARING  

PLEASE INDICATE IF YOU NEED AN INTERPRETER OR OTHER ACCOMMODATION, AND WHAT TYPE OF INTERPRETER OR ACCOMMODATION YOU NEED  
☐ I NEED AN INTERPRETER OR THE FOLLOWING ACCOMMODATION(S):  

__________________________________________________________  
SIGNATURE                                                                                                                                DATE
APPENDIX E - PLAN OF CARE

APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

___ Registered nurse, licensed to practice in the State

___ Licensed practical or vocational nurse, acting within the scope of practice under State law

___ Physician (M.D. or D.O.) licensed to practice in the State

___ Social Worker (qualifications attached to this Appendix)

X Service coordinator

Other (specify):

County MH/MR Program

2. Copies of written plans of care will be maintained for a minimum period of three years. Specify each location where copies of the plans of care will be maintained.

___ At the Medicaid agency central office

___ At the Medicaid agency county/regional offices

X By Service Coordinators

___ By the agency specified in Appendix A

___ By consumers

X Other (specify):

County MH/MR Program or designee

STATE: _________________ DATE: _________________

Revised 6/29/99
1. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

   __   Every 3 months

   __   Every 6 months

   X   Every 12 months

   __   Other (specify):
APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the IFSP is made subject to the approval of the Medicaid agency:

The IFSP is subject to approval by the County MH/MR Program, the Department's agent, in accordance with conditions and requirements established by the Department's grant agreement with the County MH/MR Program.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The IFSP will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the provider which furnishes each service.

2. A copy of the IFSP form to be utilized in this waiver is attached to this Appendix.
INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

Early Intervention promotes children's outcomes by enhancing the abilities of families.

The purpose of the Individualized Family Service Plan is to describe how early intervention can assist families in helping their young child with special needs to develop and grow.
Child's Name: ________________________________

The following information was shared by the family with ____________________________ on ____________ ____________ ____________.

The family understands that they do not have to give any information on this page in order to receive services; however, information provided will help determine appropriate services and supports. This information reflects a summary of family considerations from conversations beginning with information collected from the family's first contact, the multidisciplinary evaluation and planning for the IFSP meeting.

<table>
<thead>
<tr>
<th>Resources and Strengths</th>
<th>Concerns</th>
<th>Family's Priorities (include for child)</th>
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<tbody>
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</table>
# All About Me

**Child's name:**

<table>
<thead>
<tr>
<th>Who are the important people in my life?</th>
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<th>What activities do I like to do at home and in the community?</th>
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<th>How do I play with children, adults, and toys?</th>
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<th>What does my family want me to be able to do?</th>
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# Child's Present Abilities & Strengths

(Summary of Evaluations)

<table>
<thead>
<tr>
<th>Area</th>
<th>Present Level of Development</th>
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<tbody>
<tr>
<td>Medical/Health</td>
<td>Parent and Multidisciplinary Assessment</td>
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<tr>
<td>Hearing</td>
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<td>Vision</td>
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<td>Fine Motor</td>
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<td>Gross Motor</td>
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<td>Cognitive</td>
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<td>Communication</td>
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<td>Social/Emotional</td>
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<td>Adaptive/Self-Help</td>
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<tr>
<th>Name/Type of Assessment</th>
<th>Date</th>
<th>Person Doing Assessment</th>
<th>Agency</th>
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<tr>
<th>Other Strengths</th>
<th>Other Issues (including special health care needs)</th>
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</table>
### Intervention Plan

**Outcome/Desired Change:**

**What is happening now:**

<table>
<thead>
<tr>
<th>Objective (steps we will take to achieve this outcome)</th>
<th>Location (*Natural Environment)</th>
<th>Community Resource</th>
<th>E.I. Service</th>
<th>By Whom (can be more than one person)</th>
<th>Method (How we will teach, learn or do)</th>
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**How we, as a family, will be able to work on these objectives in our everyday lives:**

**How will we, as a team, measure progress for this outcome?**

**Our team will be satisfied we are finished with this outcome when:**

* Explain why early intervention cannot be achieved satisfactorily in a natural environment.

---

**Complete During IFSP Review**

After reviewing the outcome, we, as a family, have decided: (check one)

- We still need to work toward this outcome. Let's continue with what we have been doing.
- We still need to work toward this outcome. Let's discuss new ways to get there.
- Our situation has changed, we no longer need to work on this outcome.
- We are satisfied that we have finished with this outcome.
- Other:
## Early Intervention Services

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>CONTACT PERSON &amp; PHONE</th>
<th>AGENCY NAME</th>
<th>SVC CODE*</th>
<th>Modifier*</th>
<th>PROV CODE*</th>
<th>LOCATION CODE*</th>
<th>FUND SOURCE*</th>
<th>START DATE</th>
<th>Anticipated Exit Date</th>
<th>EXIT DATE</th>
<th>Cost per unit</th>
<th>Freq (max. for mo.)</th>
<th>Duration</th>
<th>Sub Total for one month</th>
<th>PROVIDER SIGNATURE</th>
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County designee approving EI services: ___________________________ (Signature)  

### Monthly Grand Total

## Non-Early Intervention Services

<table>
<thead>
<tr>
<th>COMMUNITY ACTIVITY/ SERVICE/ AGENCY</th>
<th>CONTACT PERSON &amp; PHONE</th>
<th>LOCATION CODE*</th>
<th>SVC CODE*</th>
<th>Modifier*</th>
<th>PROV CODE*</th>
<th>FUNDING SOURCE*</th>
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*EIRS Service Codes
ADDENDUM RECORD FOR E.I. SERVICES

Child's Name: ____________________________

ADDENDUM Date: _________________________

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>CONTACT PERSON &amp; PHONE</th>
<th>AGENCY NAME</th>
<th>SVC CODE*</th>
<th>Modifier*</th>
<th>PROV CODE*</th>
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Signatures: ___________________________    ___________________________  Monthly Grand Total (includes total page 6)

parent                                   county designee

ADDENDUM Date: _________________________

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<tr>
<th>SERVICE</th>
<th>CONTACT PERSON &amp; PHONE</th>
<th>AGENCY NAME</th>
<th>SVC CODE*</th>
<th>Modifier*</th>
<th>PROV CODE*</th>
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Signatures: ___________________________    ___________________________  Monthly Grand Total (includes total page 6)

parent                                   county designee

*EIRS Service Codes
## Child and Family Information

### Child Information

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<thead>
<tr>
<th>Field</th>
<th>Details</th>
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<tbody>
<tr>
<td>Child's Name</td>
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<tr>
<td>Gender</td>
<td>□ M □ F</td>
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<tr>
<td>Date of Birth</td>
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<tr>
<td>Social Security #</td>
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<tr>
<td>Referral Date</td>
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<td>MA Recipient #</td>
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<tr>
<td>Referral Source</td>
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<td>Other Insurance</td>
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<td>Weeks Premature (if applicable)</td>
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<tr>
<td>Eligibility based on Act 212 established condition</td>
<td></td>
</tr>
<tr>
<td>Address</td>
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<tr>
<td>City/State/Zip</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Child's School District of Residence</td>
<td></td>
</tr>
<tr>
<td>Parent's School District of Residence</td>
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<tr>
<td>Child's County of Residence</td>
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<tr>
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<tr>
<td>Primary Language</td>
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</table>

### Family Information

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Name</td>
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<tr>
<td>Relationship</td>
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<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>Phone (work)</td>
<td></td>
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<tr>
<td>Phone (home)</td>
<td></td>
</tr>
<tr>
<td>Name</td>
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<tr>
<td>Relationship</td>
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<tr>
<td>Address</td>
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<tr>
<td>Phone (work)</td>
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<td>Phone (home)</td>
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<tr>
<td>Interpreter Needed</td>
<td>□ Yes □ No</td>
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<tr>
<td>Language(s)</td>
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</table>

### Who does the family authorize to receive the IFSP?

<table>
<thead>
<tr>
<th>Team Member/Agency</th>
<th>In its entirety?</th>
<th>Particular sections</th>
</tr>
</thead>
</table>

### IFSP Meeting Dates (include date of last IFSP)

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Interim</th>
<th>Initial</th>
<th>Review</th>
<th>Annual Transition</th>
<th>IFSP</th>
<th>Other</th>
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</thead>
</table>
**TEAM MEMBERSHIP & ONGOING SERVICE COORDINATION**

**Child's Name:**

<table>
<thead>
<tr>
<th>Family's IFSP Team Members and Others Helpful to the Team:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Agency/Role</td>
<td>Address/Phone</td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Coordinator</td>
<td></td>
<td></td>
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</tbody>
</table>

**Attendance Signature Section**

1. Parent(s)/Legal Guardian
   - Parent's Rights Agreement for the IFSP to begin.
2. Service Coordinator
3. 
4. 

**Transition Plan**

(Steps for a child transitioning out of Infant/Toddler Services)

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</tbody>
</table>
APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905 (a) (32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902 (a) (27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

   ____ Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

   ____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

   X Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

   ____ Other (Describe in detail):

                  ________________________________
                  ________________________________
                  ________________________________

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

STATE: ________________________ -40- DATE: _________________
b. When the service was included in the approved plan of care (IFSP);

c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17) or section 110 of the Rehabilitation Act of 1973.

___ Yes

___ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

___ All claims are processed through an approved MMIS.

___ MMIS (Medical Assistance Management Information System) is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

___ The Medicaid agency will make payments directly to providers of waiver services.

STATE: ___________________  -41-  DATE: ________________
X The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.*

___ The Medicaid agency will pay providers through the use of limited fiscal agent who functions only to pay waiver claims.

___ Providers may voluntarily reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

*The Department will also utilize the County MH/MR Program as its fiscal agent in its Consolidated and Person/Family Directed Supports Waiver.
Appendix F Attachment

Payment for waiver services will be made to the provider of services by the County MH/MR Program with funds made available by the Department through appropriation by the State legislature.

The County is required to make payments to providers for waiver funded services within the amounts established in the County’s waiver allocation(s) based on a cost report which serves as the provider’s billing for MA eligible services.

Payments are based on individually negotiated rates or charges between the provider and the County MH/MR Program in accordance with 55 PA. Code 4300.

The Department will accept the option to exclude those individuals from the waiver for whom there is a reasonable expectation that home and community-based services would be more expensive than the Medicaid services the individual would otherwise receive in an ICF/MR. This option shall be exercised by the County MH/MR Program based on the availability of state and federal funds and reasonableness of cost provisions contained in the County MH/MR Fiscal Manual, 55 PA Code Chapter 4300. This exclusion shall not prohibit a County MH/MR Program from serving individuals under the waiver whose cost for home and community based services is more than the cost of ICF/MR care as long as the average cost for all waiver recipients is maintained within the State’s cost effectiveness limits. The Department will be responsible for maintaining necessary financial controls and structures in this area through its allocation, rebudget and audit processes.

The county is required to ensure that the billings specify the name of the child receiving services or an alternate unique recipient identifier, the name of the MA eligible services the child receives, the number of actual units of MA eligible services provided during the report period, and the approved rate for services. The County MH/MR Program also ensures that services reported are approved in the child’s IFSP, and that the child meets eligibility requirements.

The County consolidates the service reports, including any adjustments, and completes a Department of Public Welfare quarterly report. This quarterly report is forwarded to the Department. The report identifies separate funding eligible for FFP. The County makes adjustments to its quarterly report to the Department based on its review of provider reports and notification of exceptions by the Department.

Annual reports are submitted by the County to the Department for waiver services following the close of each fiscal year. These reports reflect actual service costs and utilization reported by providers. Final reconciliation is contingent on receipt of actual provider audited costs, with any subsequent final adjustments made in the following year’s reports. The annual reports are prepared in accordance with instructions and on forms provided by the Department.
Annual audits of County MH/MR programs and providers of service are in accordance with the Single Audit Act. Additional payment and fiscal safeguards are contained in the County’s Annual Agreement with the Department.

The provider of service preserves books, documents, and records related to MA eligible services for three years after the MA eligible services are furnished.

The provider of services also retains records, which related to litigation or the settlement of claims arising out of the performance or expenditures to which exception has been taken by the auditors. These records are retained by the provider until such litigation, claims, or exceptions have reached final disposition.

STATE: _______________________ -2- DATE: ________________
APPENDIX G – FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete a Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: ICF/MR

<table>
<thead>
<tr>
<th>YEAR</th>
<th>FACTOR D</th>
<th>FACTOR D’</th>
<th>FACTOR G</th>
<th>FACTOR G’</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3,308</td>
<td>3,587</td>
<td>101,167</td>
<td>3,570</td>
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<tr>
<td>2</td>
<td>3,374</td>
<td>3,659</td>
<td>103,190</td>
<td>3,641</td>
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<tr>
<td>3</td>
<td>3,441</td>
<td>3,732</td>
<td>105,254</td>
<td>3,714</td>
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<tr>
<td>4</td>
<td>3,510</td>
<td>3,807</td>
<td>107,359</td>
<td>3,788</td>
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<tr>
<td>5</td>
<td>3,581</td>
<td>3,883</td>
<td>109,506</td>
<td>3,864</td>
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</table>

STATE: _____________________ -43- DATE: ________________ 6/6/01
FACTOR C:  NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

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<thead>
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<th>YEAR</th>
<th>UNDUPLICATED INDIVIDUALS</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>3,730</td>
</tr>
<tr>
<td>2</td>
<td>3,730</td>
</tr>
<tr>
<td>3</td>
<td>3,730</td>
</tr>
<tr>
<td>4</td>
<td>3,730</td>
</tr>
<tr>
<td>5</td>
<td>3,730</td>
</tr>
</tbody>
</table>

EXPLANATION OF FACTOR C:

Check one:

____ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

X  The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

____ The State will inform HCFA in writing of any limit, which is less than factor C for that waiver year.

STATE: _______________________   -44-   DATE: ________________

06/18/01
APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC:

The July 25, 1994 final regulation defines Factor D as:

“The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program.”

The demonstration of Factor D estimates is on the following pages.
## APPENDIX G-2

**FACTOR D**

**LOC: ICF/MR**

Demonstration of Factor D estimates:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>Column A</th>
<th>Column B</th>
<th>Column C</th>
<th>Column D</th>
<th>Column E</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#Undup. Recip. (users)</td>
<td>Avg. # Annual Units/User</td>
<td>Avg. Unit Cost</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>1. Habilitation</td>
<td>3,730</td>
<td>149.94 Qtr. Hrs.</td>
<td>$22.06</td>
<td>$12,337,995</td>
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</tr>
<tr>
<td>10. GRAND TOTAL (sum of Column E):</td>
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<td></td>
<td></td>
<td>$12,337,995</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL ESTIMATED UNDUPPLICATED RECIPIENTS:** 3,730

**FACTOR D (Divide total by number of recipients):** 3,308

**AVERAGE LENGTH OF STAY:** 196 days

---

STATE: ____________________ -46- DATE: ______________ 6/7/01
APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

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<th>Waiver Year</th>
<th>1</th>
<th>2</th>
<th>X</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Waiver Service</td>
<td>#Undup. Recip. (users)</td>
<td>Avg. # Annual Units/User</td>
<td>Avg. Unit Cost</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Column A</td>
<td>Column B</td>
<td>Column C</td>
<td>Column D</td>
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<td>1. Habilitation</td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<tr>
<td>GRAND TOTAL (sum of Column E):</td>
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<td></td>
<td></td>
<td>$12,583,715</td>
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<tr>
<td>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:</td>
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<td></td>
<td></td>
<td>3,730</td>
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<td>FACTOR D (Divide total by number of recipients):</td>
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AVERAGE LENGTH OF STAY: 196 days

STATE: ___________________________ -47- DATE: ________________

6/18/01
APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

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<th>1</th>
<th>2</th>
<th>X</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Column A</td>
<td>Column B</td>
<td>Column C</td>
<td>Column D</td>
<td>Column E</td>
<td></td>
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</tr>
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<td>1. Habilitation</td>
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GRAND TOTAL (sum of Column E): $12,835,389

TOTAL ESTIMATED UNDUPICATED RECIPIENTS: 3,730

FACTOR D (Divide total by number of recipients): 3,441

AVERAGE LENGTH OF STAY: 196 days

STATE: ________________ -48- DATE: ________________

6/18/01
**APPENDIX G-2**

**FACTOR D**

**LOC: ICF/MR**

Demonstration of Factor D estimates:

<table>
<thead>
<tr>
<th>Waiver Year</th>
<th>1</th>
<th>2</th>
<th>X</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Column A: Waiver Service</td>
<td>#Undup. Recip. (users)</td>
<td>Avg. # Annual Units/User</td>
<td>Avg. Unit Cost</td>
<td>Total</td>
<td></td>
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<tr>
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<tr>
<td>GRAND TOTAL (sum of Column E):</td>
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<td></td>
<td></td>
<td>$13,092,656</td>
<td></td>
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<tr>
<td>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:</td>
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<td></td>
<td></td>
<td>3,730</td>
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<tr>
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<td></td>
<td>3,510</td>
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**AVERAGE LENGTH OF STAY:** 196 days

**STATE:** ________________________ -49-  
**DATE:** ________________

6/18/01
APPENDIX G-2

FACTOR D

LOC: ICF/MR

Demonstration of Factor D estimates:

<table>
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<th>Waiver Year</th>
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<th>2</th>
<th>X</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Column A</td>
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<td>Column B</td>
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<td></td>
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<tr>
<td>Column C</td>
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<tr>
<td>Column D</td>
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<tr>
<td>Column E</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1. Habilitation</td>
<td>3,730</td>
<td>149.94 Qtr. Hrs.</td>
<td>$23.88</td>
<td>$13,355,516</td>
<td></td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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<td>9.</td>
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<td>10.</td>
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<tr>
<td>GRAND TOTAL (sum of Column E):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$13,355,516</td>
</tr>
<tr>
<td>TOTAL ESTIMATED UNDUPLICATED RECIPIENTS:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3,730</td>
</tr>
<tr>
<td>FACTOR D (Divide total by number of recipients):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3,581</td>
</tr>
</tbody>
</table>

AVERAGE LENGTH OF STAY: 196 days

STATE: _________________  -50-  DATE: _________________

6/18/01
APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, domiciliary care certified homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

Habilitation may be offered in a foster care setting.

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following services(s) are furnished in the home of a paid caregiver. (Specify):

Habilitation may be offered in a foster care setting.

The following is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Payments to all families and caregivers are excluded from FFP under this Waiver.
APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

X The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

_____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver.

See Attachment: Room and board is paid in accordance with 55 Pa. Code, Chapter 6200, titled: Room and Board Charges.
APPENDIX G-5

FACTOR D’

LOC: ICF/MR

NOTICE: On July 25, 1994, HCFA published regulations which changed the definition of factor D’. The new definition is:

“The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program.”

Include in Factor D’ the following:

The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.

The cost of short-term institutionalization (hospitalization, NF, or ICF/MR) which began AFTER the person’s first day of waiver services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D’:

If the person did NOT return to the waiver following institutionalization, do NOT include the costs of institutional care.

Do NOT include institutional costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D’.
APPENDIX G-5

FACTOR D’ (cont.)

LOC: ICF/MR

Factor D’ is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

X Based on HCFA Form 372 for years 1998-1999 of waiver # 0324.04, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):

See attached memorandum for SSI recipients. Total cost divided by recipients is multiplied by 1.05% for COLA.
APPENDIX G-6

FACTOR G

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G as:

“The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted.”

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

___ Based on institutional cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

X Based on trends shown by HCFA Form 372 for years 1998-1999 of waiver #0324.01, which reflect costs for an institutionalized population at this LOC. Attached is an explanation of any adjustments made to these numbers.

___ Based on actual case histories of individuals institutionalized with this disease or condition at this LOC. Documentation attached (see prior page attachment for 11 ICF/MR recipients).

___ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

___ Other (specify):

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G.
APPENDIX G-7

FACTOR G’

LOC: ICF/MR

The July 25, 1994 final regulation defines Factor G’ as:

“The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.”

Include in Factor G’ the following:

The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS INSTITUTIONALIZED.

The cost of short-term hospitalization (furnished with the expectation that the person would return to the institution) which began AFTER the person’s first day of institutional services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation Factor G’.
APPENDIX G-7

FACTOR G’

LOC: ICF/MR

Factor G’ is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

X Based on HCFA Form 372 for years 1998-1999 of waiver #0324.01, which serves a similar target population.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

____ Other (specify):
## Appendix G-8

**Demonstration of Cost Neutrality**

**Loc: ICF/MR**

### Year 1

<table>
<thead>
<tr>
<th>Factor D</th>
<th>Factor G</th>
<th>Factor D'</th>
<th>Factor G'</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,308</td>
<td>101,167</td>
<td>3,587</td>
<td>3,570</td>
<td>6,895</td>
</tr>
</tbody>
</table>

### Year 2

<table>
<thead>
<tr>
<th>Factor D</th>
<th>Factor G</th>
<th>Factor D'</th>
<th>Factor G'</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,374</td>
<td>103,190</td>
<td>3,659</td>
<td>3,641</td>
<td>7,033</td>
</tr>
</tbody>
</table>

### Year 3

<table>
<thead>
<tr>
<th>Factor D</th>
<th>Factor G</th>
<th>Factor D'</th>
<th>Factor G'</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,441</td>
<td>105,254</td>
<td>3,732</td>
<td>3,714</td>
<td>7,173</td>
</tr>
</tbody>
</table>

**State:**

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-58-
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**Date:** 6/7/01
VERSION 06-95

YEAR 4

FACTOR D:  3,510   FACTOR G:  107,359
FACTOR D’:  3,807   FACTOR G’:  3,788
TOTAL:  7,317 ≤ TOTAL:  111,147

YEAR 5

FACTOR D:  3,581   FACTOR G:  109,506
FACTOR D’:  3,883   FACTOR G’:  3,864
TOTAL:  7,464 ≤ TOTAL:  113,370

STATE: ________________ -59-   DATE: ________________
       6/7/01
### EARLY INTERVENTION


<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Allocated Avg Monthly Active Caseload (AAMAC)</strong></td>
<td>8,398</td>
<td>9,321&lt;sup&gt;1&lt;/sup&gt;</td>
<td>10,089&lt;sup&gt;2&lt;/sup&gt;</td>
<td>11,239&lt;sup&gt;3&lt;/sup&gt;</td>
<td>12,520&lt;sup&gt;4&lt;/sup&gt;</td>
<td>13,893</td>
<td>15,485</td>
</tr>
<tr>
<td><strong>Allocated Average ITF Waiver Children</strong></td>
<td>548</td>
<td>1,179</td>
<td>1,713</td>
<td>2,126</td>
<td>2,345</td>
<td>2,611</td>
<td>2,911</td>
</tr>
<tr>
<td><strong>Allocated Unduplicated ITF Waiver Chd</strong></td>
<td>965</td>
<td>2,071</td>
<td>3,005&lt;sup&gt;5&lt;/sup&gt;</td>
<td>3,730</td>
<td>3,730</td>
<td>3,730</td>
<td>3,730</td>
</tr>
<tr>
<td><strong>Inc in Allocated Unduplicated ITF Waiver Chd</strong></td>
<td>1,106</td>
<td>934</td>
<td>725</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>% Allocated Average ITF Waiver Child of AAMAC</strong></td>
<td>7%</td>
<td>13%</td>
<td>17%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
<td>19%</td>
</tr>
<tr>
<td><strong>% Allocated Average ITF Chd of Allocated Unduplicated ITF Waiver Child</strong></td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
<td>57%</td>
</tr>
<tr>
<td><strong>% Allocated Unduplicated ITF Child of AAMAC</strong></td>
<td>11%</td>
<td>22%</td>
<td>30%</td>
<td>33%</td>
<td>30%</td>
<td>27%</td>
<td>24%</td>
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<tr>
<td><strong>Proj Total State/Federal ITF Waiver Svs Allocation</strong></td>
<td>$9,469,866</td>
<td>$12,337,996</td>
<td>$12,583,715</td>
<td>$12,835,389</td>
<td>$13,092,656</td>
<td>$13,355,516</td>
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</tr>
</tbody>
</table>

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1. Revised after the close of FY 1999-2000 (Philadelphia only—total was 9,205 + 116 = 9,321).
2. Proposed revised allocated avg caseload not yet approved by the Secretary. (Originally budgeted at 10,239 in FY 2001-02 carryforward = 9,205 +1,034.)
3. FY 2000-01 carryforward budget request included an additional 1,034 children during FY 2000-01 (based on EIRS data) to a revised total of 10,239. Because the projected allocated monthly avg caseload for FY 2000-01 is 10,089 (150 less than budgeted), total is revised to 11,239 in FY 2001-02; an increase of 1,150 children (budgeted increase) over FY 2000-01.
4. Based on percentage increase in AAMAC from FY 2000-2001 to 2001-2002 – 11.4% x 11,239 = 1,281. 1,281 + 11,239 = 12,520 in FY 2002-03.
5. Proposed region recommended revised allocated unduplicated ITF Waiver children (2nd rebudget adjustment) not yet forwarded to the Secretary—due to lack of State funds. (Third year of approved waiver application included 4,012 unduplicated children.)

**NOTE:** Ms. Thaler recommended that Year 1 through 5 show no growth in unduplicated children (3,730 year 1 through 5). FY 2002-03 through FY 2005-06 budgeted dollars revised based on Dana Olsen’s projections—(2% COLA added to hourly rate for FY 2002-03 (based on FY 2001-02 hourly rate) in FY 2002-03 through FY 2005-06—per Mark Weaver. The # of units of service remains the same throughout the application years.